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STATISTICAL BULLETIN

METROPOLITAN LIFE INSURANCE COMPANY

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The Longevity of Our Neighbors in Canada

A LIFE TABLE for Canada covering the years 1929 to 1931, just completed by the Statistical Bureau of the Metropolitan Life Insurance Company, reveals a number of significant facts, by comparison with the corresponding life table for the United States, as appears from the table on page 2.

1. The Canadian lives longer, on an average, than the white resident of the United States, if we omit the Province of Quebec from the reckoning. His expectation of life at birth is 60.74 years, as compared with 59.31 for the white male in the United States. For females the figures are 63.23 and 62.83 respectively.

2. Even if we include the Province of Quebec, which is somewhat less favorably situated as to mortality than the rest of Canada, it is still true from age one on, for males, and from age two on, for females, that the Canadian has a better expectation of life than the individual in our white population.

3. The Province of Quebec has a less favorable record than the rest of Canada. Yet even so, among males in Quebec the expectation of life exceeds that of white males in the United States over almost the whole range of life, namely, from age two to age eighty-two. Among females, the advantage of Quebec is restricted to ages forty-two to seventy-nine.

4. A very striking feature brought out by the recently computed life table is that in Quebec, contrary to the usual situation in most civilized countries, males have a better expectation of life than females from ages one to twenty-eight.

The life expectation gives a somewhat blurred picture of mortality conditions, because the expectation of life at any particular age depends on the mortality not only at that age, but at all ages beyond. It is, therefore, particularly instructive to study the figures in the lower half of the table on page 2, from which the following facts are gathered.

5. Infant mortality in the United States is distinctly more favorable than in Canada. The probability of dying within the first year of life is only two-thirds as great among white infants in the United States as in Canada as a whole, and less than one-half as high as in Quebec.

Expectation of Life and Mortality Rate per 1,000 at Specified Ages, by Sex, United States (whites), Canada†, Canada† excluding Quebec, and Quebec, for the Period 1929–1931*

Age	Males				Females			
	United States* (Whites)	Canada†	Canada† excluding Quebec	Quebec	United States* (Whites)	Canada†	Canada† excluding Quebec	Quebec
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	EXPECTATION OF LIFE							
0	59.31	58.90	**60.74**	55.09	62.83	61.05	**63.23**	56.62
1	62.12	**63.99**	**64.88**	61.76	64.99	64.96	**66.42**	61.67
2	61.73	**63.91**	**64.57**	**62.09**	64.55	64.78	**66.04**	61.83
3	61.06	**63.34**	**63.90**	**61.71**	63.85	64.16	**65.34**	61.35
4	60.29	**62.64**	**63.14**	**61.12**	63.06	63.43	**64.57**	60.70
5	59.47	**61.87**	**62.34**	**60.42**	62.22	62.66	**63.75**	60.01
10	55.03	**57.58**	**57.98**	**56.27**	57.70	58.31	**59.29**	55.87
15	50.46	**53.06**	**53.45**	**51.80**	53.03	53.78	**54.71**	51.42
20	46.07	**48.75**	**49.10**	**47.55**	48.55	49.43	**50.29**	47.22
25	41.81	**44.55**	**44.87**	**43.45**	44.25	45.26	**46.02**	43.24
30	37.57	**40.32**	**40.61**	**39.27**	39.99	41.14	**41.80**	39.34
35	33.36	**36.03**	**36.31**	**35.03**	35.74	36.99	**37.55**	35.40
40	29.25	**31.80**	**32.04**	**30.89**	31.53	32.84	**33.35**	31.45
45	25.30	**27.65**	**27.86**	**26.87**	27.40	28.74	**29.16**	**27.55**
50	21.54	**23.63**	**23.81**	**22.97**	23.41	24.67	**25.05**	**23.62**
55	17.99	**19.80**	**19.96**	**19.25**	19.60	20.74	**21.08**	**19.78**
60	14.73	**16.20**	**16.34**	**15.71**	16.05	17.04	**17.33**	**16.17**
65	11.79	**12.92**	**13.03**	**12.51**	12.83	13.65	**13.88**	**12.93**
70	9.22	**10.05**	**10.13**	**9.72**	9.98	10.61	**10.79**	**10.06**
75	7.03	**7.59**	**7.64**	**7.37**	7.58	8.01	**8.13**	**7.63**
80	5.27	**5.59**	**5.64**	**5.45**	5.66	5.95	**6.04**	**5.65**
85	3.94	**4.03**	**4.12**	3.81	4.22	4.39	**4.48**	**4.10**
90	2.88	2.85	**3.00**	2.49	3.11	3.22	**3.32**	**2.93**
95	2.03	1.97	**2.17**	1.52	2.24	2.35	**2.45**	**2.06**
100	1.33	1.33	**1.58**	.86	1.58	1.70	**1.79**	**1.43**
	MORTALITY RATE PER 1,000							
0	60.86	94.49	**78.66**	**123.26**	48.21	74.95	**62.65**	**97.33**
1	9.88	14.21	**10.61**	**21.24**	8.71	12.50	**9.36**	**18.55**
2	5.33	6.71	**5.11**	**9.91**	4.65	5.84	**4.55**	**8.41**
3	3.73	4.75	**3.84**	**6.62**	3.30	4.24	**3.51**	**5.70**
4	3.00	3.71	**3.12**	**4.94**	2.55	3.60	**2.87**	**5.12**
5	2.51	3.06	**2.66**	**3.93**	2.08	2.98	**2.36**	**4.30**
10	1.45	1.63	**1.56**	**1.79**	1.09	1.49	**1.33**	**1.86**
15	2.10	2.24	**2.12**	**2.53**	1.63	2.10	**1.85**	**2.70**
20	3.12	3.26	**3.07**	**3.75**	2.70	3.17	**2.77**	**4.10**
25	3.66	**3.58**	**3.46**	**4.03**	3.36	3.90	**3.42**	**5.01**
30	4.12	**3.63**	**3.52**	**3.91**	3.74	4.21	**3.68**	**5.52**
35	5.07	**4.09**	**3.92**	**4.62**	4.31	4.68	**4.21**	**5.99**
40	6.79	**5.17**	**4.89**	**6.09**	5.32	5.39	**4.89**	**6.90**
45	9.25	**6.74**	**6.44**	**7.83**	6.99	6.39	**5.92**	**7.86**
50	12.72	**9.32**	**8.96**	**10.62**	9.55	8.20	**7.80**	**9.47**
55	18.19	**13.27**	**12.93**	**14.46**	13.82	11.62	**11.19**	**12.94**
60	26.35	**19.63**	**19.17**	**21.15**	20.63	17.49	**16.58**	**20.20**
65	38.70	**30.73**	**30.05**	**33.02**	31.34	26.97	**25.69**	**30.84**
70	57.33	**47.18**	**46.16**	**50.57**	48.36	41.78	**39.90**	**47.55**
75	85.75	**73.71**	**72.16**	**78.64**	75.27	67.51	**65.38**	**73.87**
80	128.38	**114.17**	**113.24**	**116.93**	116.06	107.04	**104.97**	**112.84**
85	183.11	**172.27**	**170.83**	**176.53**	168.93	159.95	**156.75**	**169.68**
90	255.13	**254.72**	**246.19**	281.18	236.62	228.47	**222.33**	**248.93**
95	358.09	367.91	**340.63**	453.19	328.12	315.97	**304.94**	**354.46**
100	504.65	518.24	**455.47**	714.83	451.71	425.69	**407.62**	**490.20**

*Death Registration States of 1929.

†Excluding Yukon and Northwest Territories.

Boldface type indicates that Canadian figures are more favorable than those for the United States.

6. Up to age seventeen, except at age two, white males in the United States have a lower mortality than males in Canada excluding Quebec, while among females this advantage extends up to age twenty-eight.

7. After these ages, seventeen in the case of males, and twenty-eight in the case of females, the mortality is uniformly higher in the United States than in the Canadian Provinces outside of Quebec.

8. At every age and for each sex, mortality in Quebec is greater than in the rest of Canada.

9. In spite of this, male mortality in the United States is greater than in Quebec at all ages from twenty-nine to eighty-six, while among females this excess is limited to ages from fifty to eighty-four.

10. In the United States, among white persons, male mortality is in excess of female at every age of life. In Quebec, on the contrary, females have higher mortality than males over a large part of life, namely, from ages four to forty-five.

The relatively high mortality among these women is no doubt in large measure due to the strain of child-bearing, in a region where large families are still the rule.

It is a matter of great interest that our neighbors, in their rigorous northern climate, can establish a better mortality record than ours for most of the adult years of life.

The Threat of Violent Death to the Male

WHY is the mortality of males nearly everywhere higher than that of females? In the early months of life, when the relation of the infant to the external world is essentially the same for both sexes, the higher mortality of the male child can be due only to constitutional causes. That the male child is indeed somewhat more delicate than the female is indicated, among other things, by the fact that among stillbirths males exceed females by over thirty per cent. And even the principal communicable diseases of childhood, namely, measles, scarlet fever and diphtheria, show a higher deathrate among boys than among girls. But when childhood years are past, indications are that constitutional factors play a subordinate part in determining the excess mortality of the male over that of the female. Analysis of the various causes of death, as they affect the two sexes respectively, bears out this view. It is to the external factors that we must look for an explanation. Even in the very earliest years the boy is more venturesome than the girl, and throughout later boyhood, adolescence and his entire adult life, the male is subjected to external dangers not encountered in anything like the same degree by the female.

Analysis of the mortality statistics for the years 1929–1931 among white persons in the U. S. Registration States, as of 1920, clearly reveals this handicap of the male. During the pre-school period, or, to be more exact, among children of

ages one to four, the deathrate from accidents was 70.0 per 100,000 among boys, as against only 54.3 among girls. At these ages, however, deaths from violent causes form a large part of the total for either sex, taking almost as heavy a toll as measles, scarlet fever and diphtheria combined, both among boys and among girls.

During the next ten years of childhood, accidents and other forms of external violence produce a far greater number of deaths among boys than any other single cause. Over one-quarter of the deaths of boys at this age were due to accidents alone. In fact, more schoolboys die as a result of accidents than from all of the usual communicable diseases combined, including influenza-pneumonia and tuberculosis. The accident deathrate of boys of this age is almost two and one-half times that of girls, 52.7 per 100,000 as against 21.8.

The main working period of life, ranging from 15 to 49 years of age, represents the term of man's greatest exposure to the hazards of industry and of civil life. It is, therefore, not surprising to find that there are more deaths due to external violence among men than from any other cause; practically twice as many male deaths result from violence during these years as are caused by tuberculosis (all forms). The male deathrate from violence at ages 15 to 49 exceeds that of females by more than 4 to 1 (142.1 against 33.2). This age period comprises the most productive years of a man's existence; the years during which his value to society is greatest. It is precisely at this time of life that the sudden loss of the head of the family is most disastrous. We have heard much during recent years regarding the needlessly high maternal mortality rates in our country; but the question may well be raised whether the regrettably high maternal deathrate is not far exceeded in serious consequences for society and the family by the high and largely avoidable deathrate from violence of various sorts among male wage-earners. The combined mortality rate of men from accidents, homicides and suicides during this age period is just three and one-half times that of women from causes related to pregnancy and childbirth. If the deaths both from violent causes and also from puerperal causes could be entirely eliminated during this period of life, the mortality of both sexes would not be far different, namely, 376.1 per 100,000 for men as compared with 342.0 for women.

After age 50, the rising tide of deaths from the chronic or degenerative diseases tends to obscure the importance of the violent causes. Nevertheless, the latter remain among the chief causes of mortality among men to the very end of the life span. In the five-year age period 50–54, the male deathrate from external violence is exceeded only by that from organic heart disease. Violence, at this age, is responsible for more than four times as many deaths among men as among women

(220.6 per 100,000 as against 54.2).

During the next ten years of life, 55–64, violent deaths among men are outnumbered only by those ascribed to heart disease and cancer. After 65, however, violence as a cause of death is outranked by several diseases, notably heart disease, cancer, cerebral hemorrhage, nephritis and pneumonia.

Although external violence ceases to be the chief cause of death among men after age 50, it nevertheless continues to exact an increasing toll of deaths as old age approaches. Mortality rates from violence in the years 1929 to 1931 combined, among white persons, at the successive age periods were approximately as follows:

RATES PER 100,000

Age Period	Males	Females
45–49	198	44
50–54	221	54
55–64	262	78
65–74	335	167
75 and over	615	692

It is interesting to observe that, as old age advances and the greater activity of the male gradually diminishes to the level of that of the female, the accident deathrates for the two sexes more closely approach each other. In fact, we find that in extreme old age, accidents were even more frequently the cause of death among women than among men. At this stage of life, vigor ceases to be a factor in violent deaths; instead, the underlying causes are those associated with senescence.

The facts thus brought out by a study of the deaths from violent causes among males and females by individual age groups are also reflected in the average deathrates for all ages, as follows.

During the three-year period, 1929 to 1931, the average deathrate from all causes among white males in the Death Registration States of 1920 was 1,094.1 per 100,000, as against 933.7 among white females. In other words, among every 100,000 white males there were 160 more deaths than occurred among an equal number of white females. At the same time the deathrate per 100,000 from external causes among males was 148.6, while that of females was only 54.6. Thus, of the 160 extra deaths from all causes among white males, 94 or 59 per cent. were attributable to external violence. The deaths from these causes were almost three times as many among men as among women.

Fortunately, this excess is capable of reduction by means actually within our reach. The various factors in industry, in sport, and in personal habits, which create the special risk for the male, are subject to modification, if we only avail ourselves of the opportunity. Much has already been done in this direction by such organized efforts as the Safety First movement; but much more still remains to be done. When the full effect of such measures is rendered available, much wastage of human wealth will be prevented, and great gains will be secured for the individual, for the family, and for the nation.

Where the Typhoid Fever Deathrate Is Still High

As measures for the control of typhoid fever have been more and more widely extended, the disease, from a country-wide standpoint, has become a minor factor as a cause of death. This is clearly shown by the fact that, in 1932, the deathrate in seven states was less than 1 per 100,000, and in twenty states less than 2 per 100,000.

But, effective as has been the progress of sanitary science and of civic and domestic hygiene in reducing the typhoid fever death toll, current records of mortality show that we are still far from the goal of absolute control.

There were, in 1932, seven states which still had typhoid fever deathrates of over 10 per 100,000. They comprise only 13 per cent. of the total population of the country, but they contributed 45 per cent. of all the deaths from typhoid. Furthermore, there were nine more states in which the 1932 typhoid fever rate ran 5 or over per 100,000. In the area within these sixteen states, containing only 29 per cent. of the population, 71 per cent. of all the typhoid fever deaths occurred last year.

The states with typhoid fever deathrates in excess of 10 per 100,000, in 1932, were South Carolina (14.6), Kentucky (13.0), Georgia (12.5), Arkansas and West Virginia (each 12.4), Tennessee (11.6), and Louisiana (10.9). The average typhoid deathrate in this group is today about double the average rate for the entire Death Registration Area ten years ago. These are all Southern or "Border" states; and one might surmise that their high rates were due, solely, to excessive mortality from this disease among their negro populations. But this is by no means the case. In all of these states the whites suffer high typhoid mortalities, running from nearly double to more than three times the average for the white population of Continental United States. The highest figure is that for Kentucky (12.7 per 100,000), followed by Arkansas, with 10.4; Tennessee, 9.8; Louisiana, 7.8; Georgia, 7.2 and South Carolina, 5.8. The figures for West Virginia, by color, are not available at this writing.

Although it is true that, for the most part, typhoid control is a problem of rural sanitation, high mortality rates are by no means confined to the rural districts. Rates in excess of 10 per 100,000 were recorded, in 1932, in Chattanooga (12.9), and Memphis (10.6); and in Knoxville and Atlanta the rate was 9.8 and 9.5 respectively. Other cities where the typhoid mortality was well in excess of that for the population of the United States were New Orleans, Nashville, Dallas, Oklahoma City, and El Paso. The figures for Nashville are unique, in that they show that the mortality in the white population was nearly double that among the negroes; in New Orleans the typhoid fever deathrate among white persons closely approached that for the colored population.

Taken in their entirety, the figures unmistakably show, first, that there is still need for intensification in many rural areas of the successful measures that have practically suppressed typhoid fever in certain sec-

States and Large Cities Recording, in 1932, Deathrates for Typhoid and Paratyphoid Fever of Five or Over, per 100,000 Population.*

State	Deathrate per 100,000 Population	State or City	Deathrate per 100,000 Population
Alabama	5.0	Tennessee	11.6
White	3.7	White	9.8
Colored	7.4	Colored	19.8
Arkansas	12.4	Virginia	5.5
White	10.4	White	4.9
Colored	18.3	Colored	7.3
Florida	5.4	West Virginia	12.4
White	3.2		
Colored	10.8		
Georgia	12.5	Atlanta	9.5
White	7.2	White	2.7
Colored	21.8	Colored	23.0
Kentucky	13.0	Chattanooga	12.9
White	12.7	White	5.5
Colored	16.9	Colored	32.4
Louisiana	11.0	Dallas	7.4
White	7.8	White	3.8
Colored	16.5	Colored	24.7
Mississippi	7.9	El Paso	5.6
White	4.5	White	....
Colored	11.3	Colored	9.3
Missouri	5.6	Knoxville	9.8
		White	8.5
Nevada	8.6	Colored	16.4
New Mexico	6.3	Memphis	10.6
		White	8.0
North Carolina	5.0	Colored	14.9
White	3.5		
Colored	8.7	Nashville	7.6
		White	8.8
Oklahoma	9.3	Colored	4.7
White	8.2		
Colored	18.3	New Orleans	8.9
		White	8.3
South Carolina	14.6	Colored	10.2
White	5.8		
Colored	25.3	Oklahoma City	5.8

*Deaths from paratyphoid fever usually constitute about one and one-half per cent. of the total from typhoid and paratyphoid combined.

tions of the country. In New England, four of the six states registered typhoid fever deathrates below 1 per 100,000 last year. And second, that there is still a sizeable number of cities in which there is room for further achievement along approved lines of typhoid fever eradication, namely, the pasteurization of the milk supply, proper sewage disposal, regulation of food handlers, supervision of the nurturing and shipment of shellfish, control of "carriers," better supervision of cases and contacts, prompt notification to health departments of cases, purification of the water supply, inoculation with typhoid vaccine and, possibly, the elimination of privies and backyard wells.

The Decline in the Deathrate from Tuberculosis Continues

PROBABLY no item in the mortality statistics of our population gives greater encouragement than the continued rapid decline in the deathrate from tuberculosis. It is accordingly with close attention that we watch from year to year the course of the curve representing this situation. Again we bring to our readers, as we did near the close of last year, a diagram exhibiting the latest development in the trend of the deathrate from tuberculosis. Our anticipation that the deathrate for 1932 in the Original Registration States and the District of Columbia would be about 60 per 100,000, or less, has been verified and even improved upon by the facts. The figure actually observed (according to the latest provisional report for the Original Registration States) was 58.8. This is actually lower than corresponds to the more optimistic of the two trends which have been shown in the chart accompanying our successive annual surveys of the situation, and which we again exhibit here with the new point for 1932 inserted.

Incidentally, it is interesting to note that the reported figure of 58.8 coincides exactly with the deathrate for the United States as computed by the method of correlation from the deathrate of 70.2 from tuberculosis observed among the Industrial policyholders of the Metropolitan Life Insurance Company for 1932. It is found that between the deathrate d_i from tuberculosis among these policyholders and the deathrate from the same cause d_g in the general population, the equation holds

$$d_g = .765\, d_i + 5.05$$

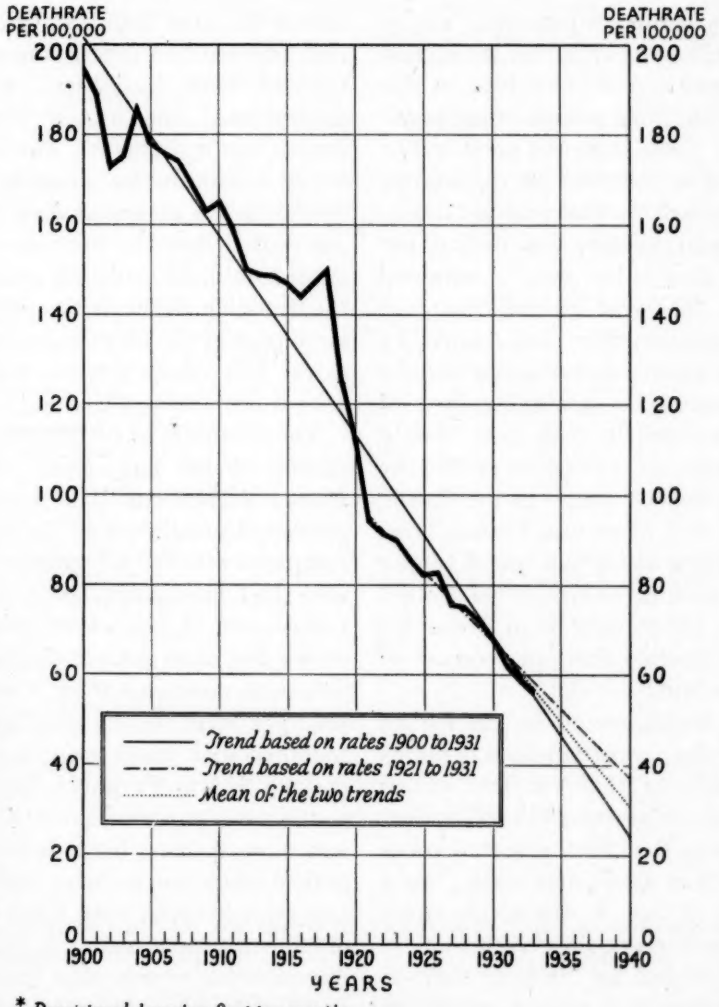
Introducing in this equation the rate of 70.2 observed among the Industrial policyholders, we find for the deathrate in the general population just the figure 58.8 actually reported. This exemplifies once more how reliable a gauge of conditions prevailing in the population at large is furnished by the deathrates currently observed among our Industrial policyholders.

In view of the marked improve-

TUBERCULOSIS - *ALL FORMS*

Deathrates 1900-1933* observed; 1934-1940 projected

Original Registration States and District of Columbia



* *Provisional, based on first ten months*

ment in the deathrate among the insured during the first ten months of 1933, we have every reason to believe that the mortality from tuberculosis will again show a drop for the general population, perhaps to a figure of about 56 per 100,000 for the whole year.

Health Record for October, 1933

UNLESS unexpectedly high mortality prevails among insured wage-earners in the few remaining weeks, 1933 will go on record as the second best health year of all time in this important cross section of the population. Only 1932 will excel it. At the end of October, the cumulative deathrate of the Metropolitan Industrial policyholders was only 3 per cent. above last year's minimal figure. The year has been featured by unprecedently low mortality among insured Canadians who have experienced the gratifying drop of 3.8 per cent. in their year-to-date deathrate as compared with the record for last year. In the Pacific Coast and Mountain States, however, there has been a rise of 4.9 per cent.; and in the rest of the United States, where more than five-sixths of the insured live, an increase of 3.4 per cent.

The health record for the month of October, nevertheless, was not as favorable as that for the corresponding month of 1932. This does not mean that the current October figure was alarmingly high. As a matter of fact, it was at the exact October average since 1920.

The record for 1933, to date, is satisfactory with respect to most of the important causes of death. It is particularly gratifying that every communicable disease listed in the table on page 11 has caused fewer deaths this year than last. We may look forward to a new minimum for typhoid fever, diphtheria and for tuberculosis; and a new low for pneumonia is probable. The cumulative deathrate for diseases incidental to the maternal state is 9.4 per cent. below the previous minimum, established only last year; but the declining birthrate has played a large part in the drop for these diseases. The suicide rate has declined 6.4 per cent. since 1932.

The deathrate in the general population of the large cities of the United States was 10.2 per 1,000 estimated population in October as compared with 9.7 in September and with 10.2 in October, 1932. Comparison with the facts for September shows that more cases of diphtheria, influenza, measles, scarlet fever and smallpox were recorded in October together with lower prevalence of poliomyelitis and typhoid fever. As compared with October, 1932, there was more sickness from diphtheria, poliomyelitis, scarlet fever, smallpox and typhoid fever, with fewer cases of influenza and measles. It is rather disconcerting to note that the diphtheria picture is not maintaining the very favorable trend of the first six months of this year.

The following table shows the mortality among Industrial policyholders for October, 1933; September, 1933, and October, 1932, together with the cumulative rates for the first ten months of each year.

METROPOLITAN LIFE INSURANCE COMPANY

Deathrates per 100,000 for Principal Causes. Weekly Premium-Paying Business in Industrial Department. All Ages (Annual Basis).*

MONTHS OF OCTOBER, 1933; SEPTEMBER, 1933, AND OCTOBER, 1932

CAUSES OF DEATH	ANNUAL RATE PER 100,000 LIVES EXPOSED*				
	Oct. 1933	Sept. 1933	Oct. 1932	Cumulative January-October	
				1933	1932
TOTAL—ALL CAUSES	811.6	744.6	746.6	876.8	851.3
Typhoid fever	2.8	2.4	3.0	1.6	1.7
Measles	.2	.4	.2	1.7	1.9
Scarlet fever	1.5	1.4	1.7	2.7	2.9
Whooping cough	1.7	2.2	1.4	2.4	3.2
Diphtheria	4.1	1.6	3.7	2.3	3.7
Influenza	6.7	3.5	7.0	21.9	17.8
Tuberculosis (All forms)	60.5	60.3	56.9	66.9	70.3
Tuberculosis of respiratory system	54.6	54.6	50.9	59.9	62.1
Cancer (All forms)	98.4	93.1	85.3	95.2	89.3
Diabetes mellitus	23.2	22.5	21.2	24.3	22.3
Cerebral hemorrhage; apoplexy	62.1	51.4	56.9	64.7	61.7
Diseases of heart†	149.2	125.4	143.9	163.7	154.6
Pneumonia (All forms)	41.4	29.8	40.1	62.1	63.9
Other respiratory diseases	10.4	7.5	7.7	10.0	9.1
Diarrhea and enteritis	17.1	19.0	14.2	11.2	11.8
Chronic nephritis (Bright's disease)	62.9	58.5	60.2	68.1	67.4
Puerperal state—Total	7.4	7.7	7.6	9.6	10.6
Suicides	8.9	9.7	10.7	10.2	10.9
Homicides	6.5	5.9	6.0	6.2	6.1
Accidents—Total	56.2	61.8	47.7	56.9	55.0
Automobile accidents	23.2	25.6	18.9	19.6	18.7
All other diseases and conditions	190.3	180.6	171.0	195.1	187.0

*The rates for 1933 are subject to slight correction, since they are based on provisional estimates of lives exposed to risk.

†Excludes pericarditis, acute endocarditis, acute myocarditis and angina pectoris.

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STATISTICAL BULLETIN,
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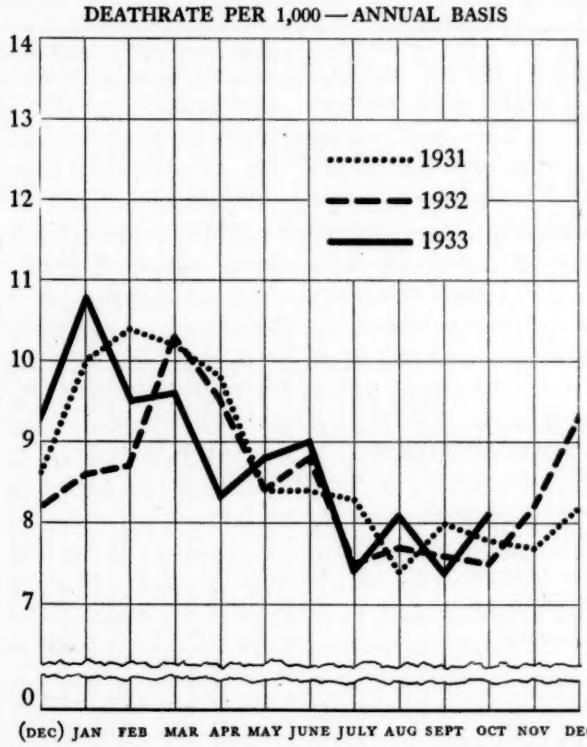
DEATHRATES FROM ALL CAUSES

in the Metropolitan Life Insurance Company
Industrial Department



1931	10.0	10.4	10.2	9.8	8.4	8.4	8.3	7.4	8.0	7.8	7.7	8.2
1932	8.6	8.7	10.3	9.5	8.4	8.8	7.5	7.7	7.6	7.5	8.2	9.3
1933*	10.8	9.5	9.6	8.3	8.8	9.0	7.4	8.1	7.4	8.1		

**Rates for 1933 are provisional.*

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